

**DEPARTMENT OF HEALTH SERVICES**

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February 11, 1999

N.L.: 03-0299  
Index: Dental

TO: California Children Services (CCS) Program Administrators and Medical Consultants, and State Children's Medical Services (CMS) Branch Regional Offices

SUBJECT: DENTI-CAL BULLETIN AND PROCESSING OF DENTI-CAL CLAIMS FOR CCS/FULL SCOPE, NO SHARE OF COST MEDI-CAL BENEFICIARIES CASE MANAGED AND SERVICES AUTHORIZED BY THE CCS PROGRAM

The purpose of this Numbered Letter is to inform county CCS programs and state CMS regional offices that, as of January 1999, the modifications discussed in CCS Numbered Letter (NL) 24-1098, regarding the requirements for processing of dental claims through the Denti-Cal fiscal intermediary, Delta Dental, are now in place as a requirement. The instructions in NL 24-1098 applies to all claims for CCS authorized services for Medi-Cal beneficiaries.

The Independent County CCS programs and the state CMS regional offices should have in place the instructions in NL 24-1098 for stamping dental claims as "CCS approved" for Medi-Cal beneficiaries receiving dental services authorized by the CCS program with claims processed through Delta Dental. Claims without a stamp indicating the name of the county CCS program or state regional office and the words "CCS approved" will not be processed for payment by Denti-Cal after February 12, 1999.

Enclosed is the Denti-Cal Bulletin Volume 14, Number 35, December 1998 that has recently been released by Denti-Cal concerning the processing instructions stated in the CCS NL 24-1098. County CCS programs and state regional offices may reproduce this bulleting (in full or in part) and attach it to the CCS dental authorization that is sent to dental providers prior to treatment.

If you should have any questions concerning this numbered letter, the Denti-Cal dental provider bulletin, or NL 23-1098, please contact Gayle Duke, R.D.H., M.S.Ed., CMS Dental Hygienist Consultant at (619) 613-9446.

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Children's Medical Services Branch

Enclosures

## Denti-Cal Bulletin



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**CHILDREN'S TREATMENT PROGRAM CONTINUES TO PROVIDE DENTAL SERVICES**

Last month, Denti-Cal distributed *Denti-Cal Bulletin*, Volume 14, Number 32, stating that the Children's Treatment Program (CTP) was suspending dental services on January 15, 1999.

The Department of Health Services has been asked by CTP to withdraw this bulletin. CTP will continue to reimburse for dental services until further notice.

If you have any questions about CTP, please call Denti-Cal toll-free at (800) 423-0507.

**PROCESSING PROCEDURES FOR CALIFORNIA CHILDREN SERVICES PATIENTS WHO ARE MEDI-CAL BENEFICIARIES**

The Department of Health Services is implementing new processing procedures for treatment that is provided to Medi-Cal beneficiaries under the California Children Services (CCS) program. CCS provides health care services to children with physically handicapping conditions up to age 21. CCS provides dental and orthodontic services for certain medically eligible conditions, including cleft palate and craniofacial anomalies. All claims and TARs that are approved by CCS will now be stamped "CCS Approved" by the CCS county or regional office.

In addition to this change, providers should be aware of the following requirements and processing procedures when submitting claims or TARs for CCS services:

Orthodontic Procedures

- Orthodontic treatment is a benefit of the CCS program and payable under the Denti-Cal program for cleft lip, cleft palate or craniofacial anomaly cases only. If Denti-Cal receives a claim for a CCS patient with documentation that states "malocclusion," the claim will be denied with the following revised adjudication reason code:

277    ORTHODONTICS    FOR    HANDICAPPING    MALOCCLUSION  
SUBMITTED THROUGH THE CCS PROGRAM FOR MEDI-CAL  
BENEFICIARIES ARE NOT PAYABLE BY DENTI-CAL.

- CCS claims must be stamped “CCS Approved” and be signed and dated by a CCS representative. Denti-Cal will not accept cumulative authorizations attached to the claim instead of the stamp. If the stamp is not present, Denti-Cal will deny the claim with the following adjudication reason code:

254      PROCEDURE DISALLOWED DUE TO ABSENCE OF ONE OF THE FOLLOWING: “CCS APPROVED” STAMP, SIGNATURE, AND/OR DATE.

All Claim Inquiry Forms (CIFs) must be submitted to the CCS county or regional office handling the case for an approval stamp. Attachments with a copy of the stamp are not acceptable. If the stamp is not present, the denied treatment will not be re-evaluated.

- When submitting a claim for orthodontic services, providers must include documentation diagnosing the patient’s condition, for example “cleft palate” or “craniofacial anomaly.” This documentation can be provided in the Comments area (box 34) of the claim form or on the authorization form attached to the claim. If the provider’s diagnosis cannot be identified, Denti-Cal will issue a resubmission turnaround document (RTD) to the provider with the following new RTD code:

83      CLEFT LIP/PALATE OR FACIAL ANOMALY?

- When submitting a claim for cleft lip/palate cases, providers must include documentation describing the dentition phase, for example “primary,” “mixed,” or “permanent.” This documentation can be provided in the Comments area (box 34) of the claim form or on the authorization form attached to the claim. If documentation is not provided, Denti-Cal will issue an RTD to the provider.

If providers submit information in response to the RTD that is insufficient, the claim will be denied with the following new adjudication reason code:

255      PROCEDURE DISALLOWED DUE TO DENTITION PHASE NOT INDICATED.

Denti-Cal cannot process Treatment Authorization Requests (TARs) for CCS orthodontic procedures. Denti-Cal can only adjudicate claims for payment. TARs should be submitted to CCS regional or county offices. Denti-Cal will deny TARs with undated claim service lines for CCS services with the following adjudication reason code:

256      THE ORTHODONTIC PROCEDURE REQUESTED HAS ALREADY RECEIVED CCS AUTHORIZATION. SUBMIT A CLAIM TO CCS WHEN THE PROCEDURE HAS BEEN RENDERED.

Procedures 551, 557 and 558 are not benefits authorized by the CCS program for Medi-Cal beneficiaries. These procedures will be denied with the following new adjudication reason code:

**257 PROCEDURE IS NOT A BENEFIT FOR MEDI-CAL BENEFICIARIES THROUGH THE CCS PROGRAM.**

- When a patient has been treated with the maximum monthly adjustments, no additional adjustments can be allowed unless CCS has authorized the additional treatment. A "CCS Request for Orthodontic Extension" form must be approved by CCS and attached to the claim for payment.
- Retainers are a benefit following the completion of all monthly adjustments for facial growth management cases. For cleft palate cases, retainers are a benefit at the completion of each phase of treatment.
- Procedure 592 is a "pre-treatment" quarterly observation for facial growth management cases prior to starting orthodontic treatment. Documentation of the craniofacial anomaly must be indicated in the comments area (box 34) of the claim form or on the authorization form attached to the claim. If this information is not submitted, Denti-Cal will issue an RTD requesting the documentation.

Non-Orthodontic Procedures

Denti-Cal will process non-orthodontic CCS claims and TARs. If the CCS stamp is present on the claim or TAR, Denti-Cal will override prior authorization and late billing requirements; however, services will be subject to all other Denti-Cal criteria. If the CCS stamp is not present, Denti-Cal prior authorization and late billing requirements will be applied.

If you have any questions regarding CCS, please contact Denti-Cal toll-free at (800) 423-0407.

**NEW AID CODE 7X–HEALTHY FAMILIES BRIDGE BENEFITS PROGRAM**

New aid code 7X will provide a "bridge" between no share-of-cost Medi-Cal and Healthy Families. Children who lose eligibility for no share-of-cost Medi-Cal as a result of changes in family income or composition will be eligible for one additional calendar month of health care benefits. This one-month "bridge" provides children with an opportunity to apply for the Healthy Families Program. If these children do not enroll in Healthy Families during the one-month "bridge," they may remain eligible for Medi-Cal with a share of cost.

The eligibility message for aid code 7X is:

**"RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST."**

This message is currently being used, because the benefits will be identical to the scope of benefits that the child was receiving under Medi-Cal with no share of cost.

The one calendar month of benefits under aid code 7X will begin the first day of the month following the last day of the receipt of benefits without a share of cost.

The one calendar month of benefits provided under aid code 7X is only available through a Medi-Cal provider or under a Medi-Cal managed care arrangement or contract. A child enrolled in a managed care plan will remain in that plan during the bridging month.

If you have any questions regarding this new aid code, please call Denti-Cal toll-free at (800) 423-0507.

**NEW AID CODES 8D AND 8K: QUALIFYING INDIVIDUAL – 1 AND – 2 PROGRAMS**

New aid codes 8D and 8K are being implemented to comply with Section 4732 of the Balanced Budget Act of 1997. The recipients in these two new aid codes will be eligible for payment of their Medicare Part B premiums through the regular buy-in process or eligible for payment of the Home Health Care portion of the Medicare Part A that was transferred to Medicare Part B.

Recipients covered by aid codes 8D and 8K will receive no dental Medi-Cal benefits and will not receive a Benefits Identification Card. These recipients, however, may have up to three months of Medi-Cal retro-eligibility. The following message will accompany eligibility verification for Medi-Cal recipients covered by aid codes 8D and 8K:

**"NO RECORDED ELIGIBILITY FOR (month/year)"**

If you have any questions regarding these new aid codes, please call Denti-Cal toll-free at (800) 423-0507.

**REVISED QUICK-REFERENCE CARD AVAILABLE FOR PROCEDURES REQUIRING X-RAYS**

Enclosed with this bulletin is a revised quick-reference card listing all Denti-Cal procedures that require the submission of x-rays for authorization and/or payment. Dental sealants have been eliminated from the list of procedures that require x-rays due to the changes in dental sealant requirements that became effective April 10, 1998. This

quick-reference card has been designed with at-a-glance information about x-ray submission requirements to help your office in preparing both paper claims and backup documentation for electronic billing. The card can be a useful tool in your office's Denti-Cal billing procedures.

If you would like additional copies of this quick-reference card, please send your request to Denti-Cal at the following address:

Denti-Cal  
California Medi-Cal Dental Program  
Printing and Publications Unit  
P. O. Box 15609  
Sacramento, CA 95852-0609